

Federal Coordinating Center Guide



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***National Disaster Medical System
A Federal Partnership.....***



Department of Health and Human Services



Department of Veterans Affairs



Department of Defense



Federal Emergency Management Agency

FOREWORD

This guide is designed as a document that will assist Federal Coordinating Centers, area coordinators, and local officials in the planning, exercise, and operations of a local plan to receive and provide definitive care to casualties evacuated to the area as part of the National Disaster Medical System (NDMS). This program requires establishing and maintaining linkage with participating hospitals and other community organizations and is best described as a federal initiative program in which federal officials support a community as it assists citizens from another community who requires definitive medical attention. As such the role of the Federal Coordinating Center (FCC) is as a facilitator, planner, cheerleader, and problem solver. Trust is at the center of the role. The community must have confidence in the word of the FCC Area Coordinator and Director.

Comments or recommended changes to this guide may be sent to the NDMS Directorate Staff through either the:

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Pentagon, Room 1C545
Washington, DC 20301-1200*

or the

*Department of Veterans Affairs (VA)
Emergency Management Strategic Healthcare Group (13C)
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Additional copies of this guide may be obtained from the above organizations.

FEDERAL COORDINATING CENTER GUIDE

NATIONAL DISASTER MEDICAL SYSTEM

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INTRODUCTION

Why NDMS? The prospect of dealing with a great civil disaster has never been so real as it is today in the United States and its protectorates. At the time of the printing of the last *Federal Coordinating Center Guide*, acts of terrorism in this country were restricted to small-scale sabotage. The likes of the World Trade Center, Oklahoma City, and the Olympic Festival bombings have significantly changed the way we think about our vulnerabilities. Although earthquakes still remain the most devastating catastrophic event that we plan for, we certainly have demonstrable evidence to consider the financial impact of hurricanes, tornadoes, floods, and acts of terrorism.

Other recent disasters in American history include the San Francisco (World Series) earthquake in 1989; the Alaskan earthquake of 1964; the eruption of Mt. St. Helens and Mt. Pinatubo in 1980 and 1991 respectively; and the explosions that devastated Port Chicago, California in 1944 and Texas City, Texas in 1947. In each of these cases, casualties were limited by the event occurring in a relatively sparsely populated area or during a time of day when fewer people were present. Such incidents will recur, however, and as populations continue to rise in most American cities, a significant mass casualty incident becomes much more possible.

A great earthquake is most likely to occur in the San Andreas Fault in California, the New Madrid Fault in the Midwest, or the Cascades Subduction Zone in the Northwest. Such an event near Los Angeles might cause 20,000 deaths and 100,000 major injuries. Eruption of any of several dormant Cascade volcanoes might threaten inhabited areas in Washington, Oregon, or California. Most major American cities with large chemical industries or transportation nodes are at risk of industrial explosions like the Halifax, Nova Scotia ship explosion of 1917. New types of disasters might occur; a toxic chemical might escape and contaminate a city as happened in Bhopal, India; or a nuclear reactor might be damaged and generate injuries from a situation like the Chernobyl disaster. Also, the threat of biological exposure to viral and bacterial agents is real, and should be accounted for in future planning. Any of the above situations can happen, the only question is when and where will they occur. The Federal Response Plan, and more specifically its Emergency Support Function #8 (Health and Medical), and the National Disaster Medical System are our nation's methodology to deal with these issues.

In addition to the need for a system to provide expanded medical support for such peacetime disasters, there are national military needs, as well, that must be considered. Department of Defense (DoD) medical planners have identified those needs as they examine the realities of technical advances in weaponry, changes in force structure, and the streamlining of the military medical system.

Current theater medical support structures suggest that the initial casualties resulting from a major conflict will be returning to the Continental United States (CONUS) shortly after a conflict begins; perhaps in as little as 48 to 72 hours. At the same time, a considerable portion of U. S. military medical assets will be deployed to the theater of

operations, further depleting its (CONUS) medical support base. In addition, the pace and intensity of the conflict may not permit time, in early phases, to mobilize a CONUS military medical capability large enough to care for all returning casualties. With the enactment of Public Law 97-174, VA and DoD have developed the VA/DoD Contingency Hospital System to provide for the CONUS medical shortfall. However, even that system may not be enough. Since it is not logical to equip and staff a standby Federal medical support system to provide for this situation, a more realistic alternative is to arrange for assistance from non-federal health facilities to supplement the Federal system.

The National Disaster Medical System (NDMS) combines Federal (DoD, VA, PHS, and FEMA) and non-Federal medical resources into a unified response that is designed to meet peacetime disaster needs as well as combat casualties from a conventional armed conflict, if necessary.

The keys to the success of this program lie in the roles of the NDMS Federal Coordinating Centers (FCCs), NDMS member hospitals, and other response elements at the local community level. Establishing and maintaining the required linkages; enrolling appropriate civilian hospitals and personnel assets; the development, testing, and assessment of local area reception plans; and the management of the system are critical elements that will determine the effectiveness of the system. This guide is designed to assist FCCs and personnel assigned to develop, administer, and execute the local NDMS plan in recognizing and understanding their roles and responsibilities in the accomplishment of these functions.

Chapter 1

The National Disaster Medical System

Background

No single city or State can achieve proper disaster preparedness for a catastrophic event. Our nation is well provided with health care resources and hospital beds. However, each urban area and State lacks the capacity to deal with an overwhelming number of casualties. For instance, California possesses a total of about 67,000 general medical and surgical beds, excluding intensive care beds. A disaster might generate 100,000 casualties. A system for dealing with disaster casualties must therefore be national in scope, and must be able to handle surges as large as those of the maximum plausible incident.

The Civilian-Military Contingency Hospital System (CMCHS)

Mass casualties are a common problem of all medical organizations. The DoD healthcare system is based on the care of a relatively healthy peacetime active duty population. Augmenting the present capacity to care for mass casualties takes time. Recognizing this, the Department of Defense, in 1980, established the Civilian-Military Contingency Hospital System (CMCHS).

The CMCHS was designed to provide access to civilian hospital beds to care for military casualties exceeding the capacity of DoD and VA hospitals. While the CMCHS carried out an extensive education and exercise program, it only contained administrative components outside its NDMS member hospitals and coordinating centers. It had no deployable medical resources. Logistics support was generated within the DoD and was concentrated on patient regulation, patient movement, and patient administration. For a non-military emergency, it was therefore a potential resource for hospital beds only. The CMCHS, however, awakened strong interest in emergency preparedness in the American health care community. This interest led to the establishment of the National Disaster Medical System.

The Emergency Mobilization Preparedness Board (EMPB)

On December 17, 1981, the President established the Emergency Mobilization Board (EMPB) to develop national policy and programs to improve emergency preparedness. The EMPB delegated health program development to its Principal Working Group on Health (PWGH). Chaired by the Assistant Secretary for Health, Department of Health and Human Services/Public Health Service (HHS/PHS); the PWGH included representation from all Federal departments and agencies concerned with health and medical care. The PWGH responded to the President's mandate by developing the National Disaster Medical System (NDMS) concept and design.

VA/DoD Resource Sharing and Emergency Operations

Public Law (PL) 97-174, the “Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act” was enacted in 1982 and established what is now the Department of Veterans Affairs as the primary backup to the DoD medical system in providing care for U.S. military casualties of an armed conflict. Thus, as a result of this legislation, it is the policy of DoD that U.S. military casualties would be provided for in the following order:

DoD Medical Treatment Facilities (MTFs)
VA Medical Centers (VAMCs)
NDMS Member hospitals (Non-Federal)

Organizational Premise

The NDMS is a partnership between the Department of Health and Human Services (HHS), Department of Defense (DoD), Department of Veterans Affairs (VA), Federal Emergency Management Agency (FEMA), State and local governments, and the private sector. It is best described in the Memorandum of Understanding (MOU) between the Department of Health and Human Services, the Department of Veterans Affairs, the Department of Defense, and the Federal Emergency Management Agency. The MOU is available either through higher headquarters or from the NDMS Headquarters in Rockville, Maryland.

Objectives

The NDMS is designed to fulfill three main objectives:

- To provide supplemental health and medical assistance in domestic disasters at the request of State and local authorities.
- To evacuate patients who cannot be cared for in the disaster area to designated locations elsewhere in the nation.
- To provide hospitalization in a nationwide network of hospitals to care for the victims of domestic disaster or military contingency that exceeds the medical care capability of the affected local, state, or Federal medical system.

Operational Concepts

The following major operational concepts form the crux of the NDMS program.

In the event of an emergency or major disaster, the Governor of an affected State may request Federal assistance under the authority of the Disaster Relief Act of 1988, PL 100-707, as amended. The resulting Presidential declaration of an emergency or a major disaster triggers a series of actions coordinated by FEMA, which may include the

activation of the NDMS, through the Federal Response Plan (FRP).

The NDMS may also be activated by the Assistant Secretary of Defense for Health Affairs in the event of a military contingency. This is only done when it is expected that DoD and VA medical assets will be overwhelmed by the returning military casualties. DoD will reimburse costs associated with this type of activation.

The NDMS works within the Emergency Support Function (ESF) #8 structure of the FRP. The NDMS includes deployable health care response capability to a disaster site, a patient evacuation system; and pre-identified, NDMS member hospitals providing definitive acute medical care.

At the local level, day-to-day coordination of NDMS planning and operations is accomplished by an NDMS Area Coordinator. Assistance in carrying out local coordination activities is accomplished by NDMS steering committees that include local hospital, medical, public health, public safety, emergency management and emergency medical services (EMS) officials, representatives of voluntary organizations, and elected officials.

NDMS Organizational Components

The following is not to be construed as a "chain of command." It is merely a hierarchical structure of the organization.

Senior Policy Group (SPG)	Made up of senior officials of the four partner agencies' emergency preparedness offices. Provides overall policy, guidance, and goals for the NDMS.
NDMS Directorate Staff	Made up of employees of the four partner agencies' emergency preparedness offices. Responsible for implementation of NDMS policies and procedures.
Assistant Secretary of Defense for Health Affairs Under Secretary for Health, VA	Respective departmental agencies responsible for overall management of NDMS operations specific to their department, e.g., Federal Coordinating Centers.
Military Surgeons General	Responsible for overall management of NDMS operations specific to their Service, e.g., Federal Coordinating Centers.

Federal Coordinating Center (FCC)	A geographic area, usually 50 miles in radius that has a minimum of 200 hospital beds, a major airport, a federal medical facility to provide support, and adequate transportation assets to provide for patient reception and distribution.
Federal Coordinating Medical Facility	A VA or DoD medical treatment facility within the Federal Coordinating Center. Its Director or Commanding Officer is responsible for providing overall management and support to the Center and the Area Coordinator
NDMS Area Coordinator	A federal employee within either DoD or VA (although a civilian is not excluded) who, under the support of the FCC recruits civilian hospitals to provide hospital care for disaster or national emergency victims, organizes local health care and support entities, and coordinates the preparation of operational plans for patient reception and local distribution.
NDMS Member Hospital	Limited to civilian hospitals, the member hospital agrees through a Memorandum of Understanding, to provide acute hospital beds (to provide medical care as specified by DoD categories) to victims of disasters or national emergencies (i.e., military conflicts).

Operational Elements

Medical Response

The primary NDMS resource to provide supplemental medical assistance is the Disaster Medical Assistance Team (DMAT). DMAT members are non-Federal volunteers, and, upon activation of the System for a national emergency, will become temporary Federal employees of the U.S. Public Health Service. The basic DMAT is a volunteer group composed of about 35 to 37 physicians, nurses, technicians, and other allied personnel, coming together and training as a volunteer unit. DMATs are, in the first instance, a community resource for supporting local emergency responders in multiple casualty incidents. Second, DMATs are also assets that may be used for

medical response within their home state. Third, DMATs are a national resource that can be called upon to provide interstate aid. There are three levels of DMATs. If a team is considered a level one team, they are capable of deployment to a distant site and will arrive in the area with enough supplies and equipment to be self-sufficient for a limited period of time, at least 72 hours. A level two team is able to deploy as a team, but may not have all the equipment and supplies to be self-sustaining in the field. A level three team is in an "organizational" phase. While the team may not be deployable, individual members of the team may be sent to round out other DMAT teams.

Much of the work of a DMAT at the disaster site will be to provide "triage" and those services necessary for casualty clearing and staging. "Clearing" refers to austere field medical care, and "staging" refers to those medical services required during patient evacuation. While the DMAT is managed by a separate organization, a DMAT in a local NDMS patient reception area may assist in providing medical services associated with receiving patients and assessing their medical needs.

Each team has a sponsoring organization, which could be a major medical center, Public Health agency, or a voluntary organization, such as a local Red Cross Chapter. The DMAT sponsor organizes and recruits the team, pre-enrolls the members, arranges for team training, and coordinates the deployment of the team.

Further information on DMATs is available in *the NDMS DMAT Organization Guide*, which may be obtained from the NDMS Headquarters Office. In addition, sample DMAT sponsorship agreements, benefit fact sheets, team member enrollment packets, etc., are also available from NDMS Headquarters.

Patient Evacuation

The second key element of the NDMS is patient evacuation. In the event that the medical systems within a disaster area are overwhelmed, there is a need for a system to move patients to another state that is simple, rapid, and can operate with limited individual patient information. The Aeromedical Evacuation System (AES), administered by the Department of Defense, US Transportation Command (USTRANSCOM), has unique aeromedical evacuation capabilities that are used day-to-day for the transportation of the DoD peacetime patients as well as participating in military and NDMS patient movement exercises. The AES formulates evacuation missions based on patient (casualty) medical and medical equipment requirements, location of care, and availability of aircraft and crews.

Three basic aircraft form the backbone of the AES. The C-9A Nightingale, a modified commercial DC9 passenger jet, can carry up to 40 litter patients, or various combinations of litter and ambulatory patients with an effective range of approximately 2500 miles. It also carries a medical crew of two flight nurses and three medical technicians. This aircraft is used during peacetime to transport eligible beneficiaries between medical facilities in the CONUS and near offshore regions.

The C-141 Starlifter is used primarily to transport military casualties from overseas to CONUS receiving sites. It carries on board equipment for 32 litters, and can be configured to carry a combination of 48 litter and 70 ambulatory patients; or, with additional litter stanchions, it can carry 103 litter patients alone.

The C-130 Hercules can carry approximately 50 to 70 litters. This aircraft has the unique capability of not requiring an improved runway for takeoff or landing. For example, it can land on short stretches of interstate highway, in a desert region, or an open field, weather and soil conditions permitting.

During an overseas military emergency, the Department of Defense, in cooperation with the Department of Transportation and U.S. commercial airlines, can activate the medical component of the Civil Reserve Air Fleet (CRAF). The Boeing 767, the primary airframe of CRAF, can be configured for 111 litters.

Definitive Medical Care

Definitive medical care begins with the arrival of patients at the FCC reception airfield. It continues through the process of triage both in transition from the aircraft and in the staging area. Next in the process is the assignment to a hospital with the capability to treat the patient, followed by proper and timely ground transportation to the hospital. Finally, and the ultimate goal of the entire process, is admittance and treatment at a member NDMS hospital.

Hospital Reimbursement

In the case of civilian victims of domestic disaster, the NDMS member hospital will identify whether or not the patient maintains a primary and/or secondary third party payer for medical care, i.e., insurance carrier, Medicare, Medicaid, etc. This information will also be provided to appropriate physicians and care providers. NDMS hospitals, physicians and other care providers, with the exception of transportation associated with casualty reception and distribution, will submit billing for patient care services to the patient's identified third party payer(s) for reimbursement. Uninsured patients will have billed charges submitted to ESF #8 via the US Department of Health and Human Services, Office of Emergency Preparedness for reimbursement from the original patient evacuation tasking order. **CIVILIAN CASUALTIES:** The NDMS agrees to assure compensation, at 110% of what Medicare would pay (at the time of the disaster) for medically necessary care for disaster-related diagnoses. **TRICARE-ELIGIBLE CASUALTIES:** The Department of Defense will pay for health care services provided the Military Health System (also referred to as TRICARE) beneficiaries in accordance with the payment rules stated in 32 CFR Part 199. The NDMS member hospital will assume responsibility for coordination of benefits, so that benefits through NDMS will be secondary to any other existing medical coverage (**other than Medicaid**). **NOTE – BY LAW, MEDICAID IS PAYER OF LAST RESORT.** If existing medical coverage provides less than the amount noted above, NDMS agrees to pay the difference.

NDMS will not compensate for pre-existing conditions except as they directly impact medically necessary care for disaster-related diagnoses. This care would be compensated at 110% of what Medicare would pay (at the time of the disaster). NDMS will not compensate for any deductible.

NDMS member hospitals will submit final bills for payment (after providing for coordination of benefits) to the Fiscal Intermediary/Third Party Administrator (that will be identified by the Office of Emergency Preparedness at the time of the disaster).

In the event the casualties are TRICARE-eligible, NDMS member hospitals will send final bills for payment (after providing for coordination of benefits) to the Fiscal Intermediary/Third Party Administrator who will be identified by the Military Medical Support Office (MMSO). P.O. Box 886999, Great Lakes, IL 60088-6999 (1-888-MHS-MMSO/1-888-647-6676). The FCC will provide liaison for all issues regarding patient care reimbursements.

Casualty Reception Transportation Reimbursement

The transportation and associated expense of reception activities will be reimbursed under the original patient evacuation tasking order. The FCC, or its designated fiscal authority, will collect appropriate billed charges for ambulance (or other transportation asset) services, medical supplies and equipment, and other support services incurred during casualty reception operations. Charges are to be submitted to ESF #8 via the US Department of Health and Human Services, Office of Emergency Preparedness for reimbursement. In the case of military casualties, billing will be submitted to the Department of Defense, Assistant Secretary (Health Affairs) for coordination through the supplemental care claims processing and payment system. The FCC will provide liaison for all issues regarding patient care reimbursements.

Return of Patients

The NDMS Area Coordinator is responsible for monitoring the care of NDMS patients placed in facilities associated with their FCC and for coordinating their discharge and their transportation back to their point of origin (or to the nearest site able to provide the opportunity for permanent domicile). Patients requiring continuing care must be returned as soon as appropriate care is available in the area from which they were evacuated and the patient can be transported safely. Transportation will be provided at NDMS expense unless covered by the patient's health care insurer or the patient does not accept transportation arranged by the FCC.

Patients requiring continuing health care or observation must be accepted by a physician at a specific health care facility at their home location prior to being returned. Patients not requiring medical care en route will be provided transportation procured through government sources by the FCC. Civilian patients who are ambulatory and do

not require en route care will be issued tickets on the most appropriate commercial carrier.

The FCC will be responsible for arranging the return of the remains of patients who expire during their NDMS-sponsored care to the custody of family or other legally responsible person. Burial arrangements will be made by the FCC at NDMS expense when no legal custodian is identifiable.

Upon discharge of patients from NDMS responsibility, copies of the complete records of patients' care, transportation, and/or disposition of their remains will be sent to NDMS headquarters for permanent, confidential retention.

Chapter 2

NDMS Activation and Operations

Introduction

The National Disaster Medical System is a part of a continuum of care that begins at the disaster site or in the battlefield and terminates with the patient's return home or back to military duty. The activation and operation of NDMS must ensure the efficient and timely response, stabilization, evacuation, reception, hospitalization and definitive care of the patient.

System Activation

The System may be activated in one of three ways:

- In the event of a domestic peacetime disaster, the Governor of an affected state, on advice of local or county authorities, may request Federal assistance under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act. In general, the Governor requests a Presidential declaration of a disaster or emergency through the FEMA Regional Director. Such a Presidential declaration triggers a series of Federal responses coordinated by FEMA. These may include requesting the activation of NDMS by the Assistant Secretary for Health, HHS, when appropriate.

- A State Health Officer may request NDMS activation by the Assistant Secretary for Health, HHS, in situations where there is no Presidential disaster declaration. Such activation would take place under authorities provided by the Public Health Service (PHS) Act. However, without the request being part of a federally declared disaster, the state would be liable for the costs of using the system.

- When military casualty levels exceed or are expected to exceed the capability of the DoD and VA medical systems, the System may be activated by the Assistant Secretary of Defense (Health Affairs). Costs associated with this activation will be borne by DoD.

Upon system activation, the National Disaster Medical System Operations Support Center (NDMSOSC) will be opened and staffed by representatives of HHS/PHS, DoD, VA and other Federal agencies as required. In a civil emergency, the NDMSOSC will work in cooperation with ESF #8 at the Disaster Field Office (DFO) and the Management Support Unit (MSU) at the disaster site, the affected state's health department, and the Global Patient Movement Requirements Center (GPMRC). In a military contingency, the principal interface will be directly between GPMRC and the NDMS Area Coordinator, and the NDMS Area Coordinator with the local participating NDMS hospitals.

Pursuant to Executive Order 12656 (November 1988), if the system is activated in a domestic disaster, the lead agency will be HHS; in a military contingency the lead agency will be DoD. Each participating Federal agency will be responsible for managing and directing its own resources. For example, the NDMSOSC will determine the level of FCC participation required, inform the VA and the DOD, which will inform their respective FCCs that they have been activated by the NDMSOSC.

Concept of Operations - Domestic Disaster

Assessment

After a Presidential declaration has been made, FEMA will deploy an ERT-A (Emergency Response Team) which includes an ESF #8 representative. The ESF #8 representative's primary task is to assess the need for activation of ESF #8 as well as the NDMS. Additionally, the ESF #8 representative will assess the potential for patient evacuation.

Mission Tasking

Subsequent to the ERT-A assessment, FEMA will establish a Disaster Field Office (DFO) in or near the disaster site. As part of the DFO, an ESF #8 representative will maintain interface with state and local health officials in order to process assistance requests. To that end, it is the responsibility of the ESF #8 team at the DFO to assure that formal, detailed taskings are issued with sufficient funds to provide appropriate authorization and to cover all potential costs for the activation of all NDMS elements required to assist the affected State. It is within this context, for example, that a request to evacuate medical patients from the disaster site will be tasked for implementation by GPMRC. That tasking will include the authority to evacuate patients from the disaster site, provide for transportation to an FCC and within the FCC to a member hospital, fund hospital care, and to provide for return of these patients to their communities.

Patient Regulating and Aeromedical Operations

Once patient evacuation has been determined to be necessary and a tasking order has been issued, GPMRC will issue bed-reporting instructions to those FCCs activated for patient reception, receive medical information about victims, determine medical equipment needed for flight, coordinate movement to the airport, and communicate with NDMS Area Coordinators regarding aeromedical missions dispatched to the disaster area and on to the FCCs. Note that this process does not exclude the possibility that the need for evacuation could be so great that *immediate* movement would be required, thus minimizing the scope of information collected.

FCC Patient Reception Operations

Prior to the arrival of patients, the NDMS Area Coordinator will activate the area's reception plan, alert triage teams, litter bearers, administrative teams, patient staging

teams, and transportation assets. Upon the arrival of patients, the NDMS Area Coordinator will notify the GPMRC of that arrival. The NDMS Area coordinator will then further regulate and move the patients to local member hospitals.

Concept of Operations - Military Contingency

The concept of operations for a military contingency is essentially the same as in a disaster with the exception of the following:

- The method of activation of NDMS (See *System Activation*, above)
- The NDMS Area Coordinator must inform the nearest DoD medical care facility of each branch of service that DoD patients of that service have arrived at the FCC.

Chapter 3

Federal Coordinating Center (FCC) Roles and Responsibilities

Introduction

NDMS FCCs have critical roles to play in the successful organization and operation of the system in the local community or communities for which they have been assigned responsibility. These critical roles may be summarized as follows:

- Represent the NDMS
- Solicit/Organize Community Participation
- Facilitate/Maintain Hospital Enrollment
- Collect/Report Hospital Bed Availability Data
- Coordinate Area Operations Plan
- Coordinate Annual Exercises
- Coordinate Local Operations During Activation

The remainder of this chapter is devoted to detailed discussion of each of these roles.

Represent the NDMS

Although all NDMS FCCs are coordinated by either Military Treatment Facilities (MTFs) or VA Medical Centers (VAMCs), the role of NDMS FCC transcends those affiliations. The NDMS FCC really represents the Federal Government, in general, in dealing with the civilian medical community and State and local authorities. The Commander or Chief Executive Officer of the facility is considered the FCC Director and has overall control and responsibility for this program. The NDMS Area Coordinator is responsible for the day to day operation and readiness of this program. They should approach their communities and geographic areas as local agents for the broad Federal coalition that comprises the NDMS.

Local NDMS Area Coordinators are the essential link in obtaining and maintaining community participation in the System. As such, they must be sensitive and responsive to the unique economic, governmental, organizational, and political characteristics of the assigned local community; and tailor/adapt briefings presentations, meeting sites, and protocol considerations accordingly.

Solicit/Organize Community Participation

The NDMS Area Coordinator should seek the support of local, regional, and state disaster emergency services agencies, hospitals, and disaster medical and health services officers. Also influential in local disaster services are public safety officials, including both police and fire services. About half of the major metropolitan areas of the nation are served by emergency medical transport services in their jurisdictions, and

many have regional coordinating networks and disaster management responsibilities that parallel those of NDMS. In some areas, especially those not served by regional EMS agencies, local or district health officers may be responsible for disaster medical services. Public sector emergency and disaster services personnel have many organizations of their own, notably disaster councils, emergency services associations, rescue and paramedic associations, and associations of communications officers. Where such organizations are based in the NDMS area, their support should be sought.

The academic community has several potential sources of support. Academic medical centers frequently serve as trauma centers for the region. Prominent faculty members may be recognized as community leaders in emergency medical care. Many such medical centers have already organized response teams for local disasters, and might be favorably inclined to affiliation with NDMS. Elsewhere among academic institutions, many community colleges possess emergency medical technician training programs (basic and advanced), and their faculties are involved in support of local disaster response.

The military reserve community is another potential source of support. The endorsement of prominent Reservists and National Guardsmen who occupy positions of influence in the civil community may be helpful. Many of these are leaders of the local health care community.

Additional resource support may be sought from local businesses that may be directly involved in supplying agencies involved in disaster response, such as for pharmaceuticals, medical/surgical supplies, medical gas, uniforms, communications equipment, EMS equipment and vehicles, etc. Local sporting goods stores, Army-Navy stores, or large store chains may also be willing and able to support various aspects of the total NDMS goal.

Several voluntary agencies exist principally to serve emergency needs. Among these is the American Red Cross, whose chapters span the nation. Its support for disaster relief is the principal reason for their existence. In many areas, other agencies such as the Salvation Army and other religious affiliated organizations are also active in disaster relief and should be considered as potential supporters of NDMS.

Early in the organization process, the assistance of these voluntary agencies will mainly be in the form of identifying leaders of the community emergency response network and other important contacts who should be educated about the NDMS. Later, as organization progresses, such supporters can be enlisted to assist in the promotion of the program, enrolling institutional participants, recruitment of capable sponsorship, identifying leadership for NDMS DMATs, and training of hospital personnel and DMAT members. The NDMS FCC should prepare and keep a list of resources from participants already in the NDMS. This list should be compared with the NDMS FCCs needs to maintain a current, effective organization.

Facilitate/Maintain Hospital Enrollment

Criteria for Enrollment

NDMS seeks voluntary commitments of beds from hospitals accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Hospital Association (AOHA). General acute care hospitals should be operating 100 beds or more, although smaller hospitals may be considered if they express a desire to participate or possess key specialty beds. There is no minimum in overall size of bed commitment for psychiatric hospitals. Participating hospitals are required to sign a Memorandum of Understanding with the National Disaster Medical System and participate in annual exercises of the System. Since JCAHO requires that hospitals conduct at least one patient movement exercise per year, NDMS drills are an ideal method of satisfying that annual requirement.

In general, NDMS participating hospitals should be within a 50-mile radius of the airport or Air Force Base that would be the likely arrival location of NDMS patients. This is to help assure that local ground transport of patients to a participating hospital will require one hour or less. Hospitals beyond a 50-mile radius may be accepted for enrollment at the discretion of the NDMS FCC.

Memorandum of Understanding

A hospital wishing to participate in NDMS must complete a Memorandum of Understanding. The Memorandum of Understanding will be signed by the Chief Executive Officer of the NDMS member hospital and the assigned NDMS Area Coordinator who will sign the agreement as the local representative of the NDMS. A sample of this agreement is included in the MOU Annex. This agreement should be prepared in two copies; one for the NDMS files of the FCC, and one for the participating hospital which is party to the agreement.

Program Development

Each FCC should have a specific community based person designated as the lead contact for NDMS. While federally coordinated, to be successful, the program needs to be built on how the community normally responds to a local medical emergency. It is important to actively involve state and local health associations and emergency management agencies, hospital councils, medical societies, and local EMS agencies. It is essential that the lead NDMS FCC staff person provide ongoing education and information to their own institution's personnel. Local mobilization of the reception program begins with the NDMS FCC. FCC personnel, beyond those normally involved in NDMS activities, may be called upon to assist in the management of the program during an activation.

Determination of Bed Commitment

As part of initial enrollment in the NDMS, non-Federal hospitals will indicate in the NDMS Memorandum of Understanding (MOU) a general total "Minimum" and "Maximum" number of beds to be committed. The "Minimum" represents the number of beds the facility could make available within 24 hours of notification of an NDMS activation; the "Maximum" represents the number of beds that could be made available within 72 hours. Normally, the "Minimum" represents the facility's judgment as to the average daily patient census versus the average daily staffed and equipped capacity of the hospital. The "Maximum" represents the facility's judgment as to additional beds that could be provided if supplemental temporary staff could be hired and/or the hospital administration and medical staff decided to defer admissions for elective surgery, discharge current patients early, etc.

Another factor that may determine initial bed commitments is the number of current hospital staff who have Armed Forces Reserve commitments (including members of the National Guard). The number of staff having such commitments, and the ability of the hospital to locate and hire temporary replacement personnel, may affect the number of available beds, particularly during an NDMS activation for care of military casualties of an overseas conventional conflict.

Internal information developed by a hospital in the course of its analysis is not to be provided to the FCC, any element of the National Disaster Medical System, or any level of the government.

Collecting and Reporting Hospital Bed Availability Data

Upon receipt of instructions from GPMRC, the NDMS Area Coordinator collects and reports to GPMRC, bed availability data from each participating NDMS hospital.

Public Relations

NDMS Area Coordinators are encouraged, with the advance consultation and concurrence of the participating hospital administrator, to obtain news media coverage of the agreement signing ceremony. A plaque signifying NDMS participation is to be presented to hospital representatives at the signing. Request for plaques will to submitted to the National Disaster Medical System Headquarters Office.

Coordinate Area Reception Plan

The NDMS FCC is responsible for coordinating the development, exercise, and evaluation of a local NDMS reception plan. This plan should address, as a minimum, the following areas:

Concept of Operations

- System Activation
- Alerting of Participating Hospitals
- Patient Reception
- Patient Administration
- Communications
- Transportation
- Personnel Administration
- Test (Exercise) and Evaluation
- Public Relations and Media Information

Plan Development

The development of a local plan is critical if NDMS is to be a viable system. The key to success is the thoroughness and effectiveness of local level planning. Each local community in which the NDMS is organized is unique. The degree of sophistication of current community disaster planning and the availability of local resources that can be incorporated into the NDMS plan will vary among communities. Each NDMS plan must be tailored to its community; thus local planning cannot be accomplished without the support, involvement, and coordination of the local areas medical community. Most communities have an Airport Disaster Plan, Mass Casualty Incident (MCI) Plan. In many instances, this can be used as a basis for the NDMS Reception Plan or at least the same people and organizations that developed these plans should help develop and manage the NDMS plan. Local officials who help develop the plan will be familiar with and will accept use of their own plan for NDMS disaster response.

In the plan development process, there are a number of the individuals and/or agencies that the NDMS FCC should contact. These include local emergency medical service organizations, county and city health departments and disaster planning agencies, disaster planning committees of medical societies and hospital associations, and selected individuals who are leaders in the local health care community.

Exercises

As in any planning effort, the development of the NDMS local area plan does not cease with its publication. Planning is a dynamic process which must not only periodically test the plan that is developed, but also provide feedback to the planner to correct deficiencies or adjust the plan in view of changing circumstances. Therefore, the plan must be exercised. Equally important, in view of the critical importance of the involvement of the local community in NDMS planning, exercise of the NDMS operations plan will keep it visible and regarded as a viable concept. Additionally, among the incentives for civilian hospitals to participate in NDMS are annual exercises, that will meet the requirements of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the American Osteopathic Hospital Association (AOHA) - for an annual external disaster drill.

Each hospital or agency participating in NDMS should be afforded an opportunity to participate in an annual NDMS exercise which will meet JCAHO or AOHA external disaster drill accreditation criteria. Exercises should be sufficiently comprehensive to permit an assessment of participating hospitals/agencies ability to perform according to the area NDMS reception plan. In areas where annual drills are not conducted, opportunity exists for establishing an annual exercise that the NDMS steering committee can coordinate. This may be accomplished by exercising functions common between the NDMS Reception Plan and local emergency response plans.

Exercise Funding

There are no funds available for compensation of non-Federal organizations and/or agencies to support participation in NDMS exercises.

Coordinate Local Operations During Activation

Initial Actions

The following is a generic approach to the actions an NDMS Area Coordinator will take upon activation of the NDMS. It is recognized that not all FCCs will follow the same courses of actions in the same manner.

Notification to FCCs will be through the normal chain of command (DoD or VA) that their NDMS area has been activated as part of an NDMS activation. This notification should indicate if patient evacuation is imminent.

FCCs will activate their area operations plan according to the appropriate level of readiness as indicated by the activation notification. This will typically include, at full activation, alerting all member hospitals and all elements of the reception program. FCCs may begin local bed reporting to a central collection point in anticipation of bed reporting instructions from GPMRC.

Upon receiving bed-reporting instructions from GPMRC, the FCC will initiate local bed reporting, if not already done. In preparing to report bed availability to GPMRC, FCCs with multiple areas that involve separate reception sites must insure that bed reports are submitted separately for each reception site. If these sites have not been previously established during the planning process, it may not be possible to accomplish that during active operations. FCCs should note that the selection of a large, busy airport must include coordination with the airfield and the FAA to ensure "first in, first out" privileges for the evacuation aircraft.

FCCs should ensure that open communications and liaison are established with GPMRC for the receipt of regulating decisions, evacuation mission information, and patient medical data, if available.

Depending on the information received from GPMRC, the FCC may begin the process of regulating patients to specific local hospitals. This is the sole responsibility of the FCC.

Patient Reception

Upon arrival, the reception team medical leader will receive a manifest and medical briefing from the medical crew director of the aircraft. This briefing will serve to ensure that the most severe cases will be off-loaded first for immediate transportation or stabilization. Following the briefing, patients are either (1) moved directly to awaiting transportation and taken to a hospital, and/or (2) off-loaded and transferred to a patient staging/holding facility depending upon the severity of injuries and/or practicality. In either case, skilled personnel are required to unload the vehicle, identify, examine, sort and transport the patients to the hospitals. Several models for reception teams have been used successfully. The type of reception team will depend on what is comfortable to the local community. Some communities use an adaptation of the local MCI plan where the fire bureau manage the “scene” with support from EMS and police. Other communities have developed separate reception teams specifically for this activity.

Patient Redistribution Procedures

The FCC patient reception activity must be able to match the individual patients requirements for care with bed capabilities as reported by the participating NDMS hospitals. This necessitates close coordination between the reception activity, local EMS coordinators, the FCC, and GPMRC. While the FCC is responsible to assure that reception, sorting, staging, transportation and hospitalization of arriving patients occurs, this activity works best when local officials who are responsible for similar function on an ongoing basis are involved. The FCC may need to provide administrative support for patient control and proper patient accounting.

The NDMS FCC will be responsible to assure that an admission summary for each arriving patient is completed. The FCC is responsible to maintain the location and diagnosis of each patient in the region. An estimated length of stay will be established and maintained for each patient. This summary should be available to federal emergency management officials who will be responsible to share this information with the affected state officials. If the NDMS reception program is activated for a military contingency the FCC will provide this summary to DoD upon request.

Local Transportation

NDMS FCCs are responsible for arranging transportation to move patients from arrival sites to local NDMS member hospitals. It is possible that 50 to 100 patients could arrive simultaneously in a local NDMS area with little advance notice. NDMS FCCs must have incorporated into the NDMS Area Operations Plan, procedures to obtain vehicles and personnel to transport arriving patients on relatively short notice. Among the types of vehicles that could be used are the following:

DoD hospitals have daily use of ambulances. The precise source, availability, and capacity of these vehicles should be recorded in the government vehicle section of the transportation plan. Other Government vehicles, including those not normally used to transport patients, may be made available in an emergency. These include troop transport buses, school buses, panel trucks, vans, and other similar types of vehicles. Government vehicles are available from a number of sources, for example:

- Local military installation(s)
- Neighboring military installation(s)
- Local National Guard and reserve organizations
- U.S. General Services Administration (GSA) motor pools

It is important that these vehicles be assessed for their patient carrying capability, inventoried, and tabulated in the patient transportation plan. Additionally, advance coordination should be effected with the authorities that will make these vehicles available. Vehicles which are scheduled to move to an overseas theater of operations early in mobilization, or are committed to a potential military mobilization effort, should not be included as patient transportation assets during military contingencies,

Most urban communities have relatively advanced Emergency Medical Services (EMS) systems that have at their disposal vehicles and trained emergency medical technicians. It is generally expected that these systems will be an integral part of the FCC reception plan and program.

NDMS FCCs may arrange to obtain the services of commercial and school buses to transport ambulatory patients if the need arises. Although most buses cannot accommodate litter patients; their capability to be used for this purpose should be assessed.

Hospitalization

Maximum effectiveness in the overall hospitalization process can be obtained only through close coordination and cooperation between the NDMS FCC and the participating hospitals in the NDMS Patient Reception Area. This effectiveness is achieved by linking the NDMS FCC with the NDMS member hospitals through the patient administration activity of each medical facility.

The NDMS FCC assumes administrative responsibility for hospitalized patients. This responsibility begins upon a patient's arrival and continues until the patient is either returned home or, in the case of military casualties, returned to the responsible service personnel system for processing and assignment to a military unit or discharge from active duty, as appropriate.

Upon admission to a participating NDMS hospital, the patient's day-to-day medical management and care will be accomplished by the medical staff of that hospital. The

hospital will provide for the complete acute care of the patient using their own procedures and forms.

NDMS member hospitals will be required to provide the following to the NDMS Area Coordinator:

- a daily bed availability report
- a daily admission and disposition list (indicating the expected length of stay)
- a narrative summary upon discharge of the patient.

In some cases, during and after a military contingency, military patient administration teams may be established at NDMS member hospitals to coordinate military patient and personnel matters between NDMS member hospitals, the NDMS FCC, and the local military hospital. The decision to establish the team, as well as its makeup, will depend upon the projected workload, communications capability, distance between participating hospitals, patient needs, and the requirements of the participating hospital as well as the NDMS FCC. However, FCCs should coordinate with the nearest military hospital to establish procedures to be followed for all military personnel, regardless of service.

Claims Submission, Processing, and Payment

Refer to the section entitled "Reimbursement for Member Hospitals and Patient Reception" in Chapter One.

Deceased Patients

Military patients who expire during evacuation or following admission to an NDMS hospital will be handled in accordance Military Service policies, regulations, and procedures. Civilian disaster victims who expire during evacuation or following admission to an NDMS hospital will be handled in accordance with procedures of the local medical examiner. Upon learning of the death of a civilian NDMS patient, the NDMS FCC should immediately notify the NDMS Operations Support Center (OSC)/Headquarters Office in Rockville, Maryland, 1-800-USA-NDMS. The NDMS OSC/Headquarters Office will then assist in determining if and how the deceased will be returned to his/her community for final disposition.

Assist in DMAT Organization/Training/Readiness

DMATs have as their purpose the provision of austere field medical care at a local disaster site; some may also be capable of deployment to distant locations to supplement local and state level medical resources in a large-scale disaster. While the Reception Program and the DMATs are separate programs, there may be opportunities to exercise together. If a DMAT exists in the community, the FCC Area Coordinator should consider working with the DMAT team. However, remember that the primary purpose of the DMAT is as a deployed resource. If the DMAT is integrated into the

reception plan, an alternate plan needs to be in place to receive, sort and transport patients from the reception point to local hospitals.

Discharge and Return of Patients

Purpose

The purpose of this annex is to provide additional guidance to assist the National Disaster Medical System (NDMS) Federal Coordinating Center (FCC) Area Coordinator in his or her duties and responsibilities for managing the return of patients from definitive care back to their home of record. This annex is a supplement to the NDMS FCC Guide, dated April 1999.

Responsibility

The receiving Area Coordinator is responsible for monitoring NDMS patients placed in the FCC's member hospitals. Associated with this is the responsibility for coordinating the patients' discharge and transportation back to their point of origin. The Area Coordinator is also responsible for coordinating with Department of Health and Human Services, Office of Emergency Preparedness for the reimbursement to the FCC for the costs of return transportation.

Concept

The NDMS has a basic responsibility to provide return transportation, at government expense, for the patients it has evacuated to an FCC for the provision of inpatient hospital care.

The Global Patient Movement Requirements Center (GPMRC) is the single conduit for the movement of all NDMS patients, regardless of the mode of transportation.

Unless otherwise directed by higher authority, use of the DoD Aeromedical Evacuation System (AES) for patient transportation is limited to "space available," and the GPMRC may not create missions or add to the itinerary exclusively for NDMS patients.

NDMS may at any time elect to contract for aeromedical evacuation for the sole use of NDMS. Recommendations to do so by the Area Coordinator must be justified in terms of cost and the number of patients to be moved.

Patients who do not require inpatient care, i.e., evacuated but only requiring outpatient services in FCC member hospitals, should have lodging arranged by the supporting FCC. Such lodging should be minimized and the patient transported home as soon as possible. The cost of such lodging is reimbursable to the FCC from NDMS.

Procedures

Patients will not be considered for return transportation prior to the determination by the patient's attending physician that the patient can be transported safely. The mode of return transportation (DoD AES or commercial air travel being considered the preferred modes) and the selection of the patient's destination will be made by the Area Coordinator utilizing the most cost-effective alternative, in coordination with the patient, the patient's family, the attending physician, and the GPMRC. For patients moving to another inpatient care facility, the destination-accepting physician must approve the transfer. Patients (or the patient's family) who decline coordination for transportation by the Area Coordinator are subject to loss of government payment for transportation. The Area Coordinator must obtain the declination in writing.

Transportation: The primary mode of transportation is the DoD AES, followed by scheduled commercial airlines, and at last resort, air ambulance services. Ground transportation may be considered providing the condition of the patient has been taken into account.

Transportation other than the DoD AES will be procured by the Area Coordinator through government travel offices in order to minimize costs. Upon accomplishment of alternate transportation, the Area Coordinator will notify GPMRC so that the patient record can be annotated.

Return transportation for non-military patients in a domestic disaster arranged by the FCC, will be provided at NDMS expense as provided for in the Mission Tasking Order for aeromedical evacuation unless covered by the patient's health care insurer or if the patient does not accept the transportation arranged by the FCC (or to the nearest site acceptable to the patient and/or family which is able to provide the opportunity for permanent domicile).

Patient Considerations: Patients requiring continuing inpatient care may be returned once appropriate care is available in the area from which they were evacuated and the patient can be transported safely. Written proof from a physician who is willing to accept and admit the patient at the destination is required.

Patients requiring continuing outpatient health care or observation after discharge from inpatient care may be returned once appropriate care is available in the area from which they were evacuated and the patient can be transported safely. Written proof of an accepting physician is encouraged but not required.

Patients not requiring inpatient medical care at the FCC should receive transportation procured by the Area Coordinator through government sources on the same day or the next day.

Preparation and Request for Movement: In accordance with the requirements of the Global Patient Movement Requirements Center (GPMRC), attending physicians will identify the readiness of patients for movement 72 hours (minimum) prior to discharge and will notify the Area Coordinator who will, in turn, initiate a movement request to

GPMRC. Patients requiring continued inpatient care or observation would not be discharged from the FCC member hospital until the day of transportation.

Upon receiving notification that a patient is ready to be discharged and requires transportation (of any mode), the Area Coordinator will submit a Request for Space Available Travel to the GPMRC (method of transmission will be specified at the time of the operation). This form provides information needed to determine if the DoD AES can provide transportation and also constitutes entry into the Patient Movement System for patient tracking.

The GPMRC will review the request and will return the form to the Area Coordinator with approval or disapproval. If the patient can be accommodated by the DoD AES, the Area Coordinator will complete the designated patient information form(s). If the patient cannot be accommodated by the DoD AES, the Area Coordinator will coordinate alternative transportation. Regarding the patient's medical clearance for travel, the Air Mobility Command Flight Surgeon is the final authority for approval for flight.

Claims certification and submission: The Area Coordinator has the responsibility for certification and submission of all claims. See reimbursement annex (to be developed).

Patient Discharge Planning

The NDMS hospitals must communicate the post discharge requirements of the patients to the Area Coordinator. The FCC Directors must ensure a plan is in place to manage continuation of care, follow-up medications, daily personal needs, and to ensure transport is arranged prior to discharge. NDMS hospitals should start discharge planning 72-hours prior to discharge. NDMS hospitals may have to augment their staffing to facilitate the discharge of large numbers of patients.

If patients' homes are unsuitable or uninhabitable for return at the time of discharge, the Area Coordinator ensures that the patients are registered for Federal Disaster Assistance and that temporary accommodations are secured through other local, State and Federal programs.

Communications

Purpose

The purpose of this annex is to provide additional guidance to assist the Federal Coordinating Center (FCC) National Disaster Medical System (NDMS) Area Coordinator in his or her duties and responsibilities for managing communication procedures, processes, and equipment in regard to patient reception operations. This annex is a supplement to the NDMS FCC Guide dated April 1999.

Communications Inventory

Below is a listing of the communications equipment and suggested maintenance testing that is the recommended (minimal and supplemental) equipment for effective communications during contingency operations. This list has been compiled based on experience gained through large-scale exercises by several senior NDMS Area Coordinators.

Recommended Minimum Equipment	Frequency of Testing
Laptop computer with cellular modem access and alpha paging software	As needed
Printer	As needed
Fax machine	As needed
STU III Phone	Quarterly
Satellite phone with auxiliary antenna	Monthly
Cellular phone with backup batteries	As needed
VHF 7-10 channel, 5-watt handheld radio with charger and extra battery	As needed
Family Radio System (FRS)	As needed
Handheld GPS	Monthly
Radio frequency scanner	Monthly
Weather radio with battery backup	Weekly
Pager	As needed
Uninterruptible Power Supply (UPS)	Semi-annual
Auxiliary power (as needed)	Quarterly

Recommended Supplemental Communication Supplies

Locked cargo boxes with wheels or luggage carriers
 Telephone cords with connectors
 Extension cords with surge protectors
 Electrical toolkit with flashlight
 Batteries

Training

The NDMS Area Coordinator should be familiar with equipment operations in addition to training pertinent staff. Equipment manuals should be kept in a central location within the FCC office.

Exercising

FCC Equipment familiarization and testing should be built into annual NDMS exercises.

Additional Communication Resources

- Shared Resources (SHARES) HF radio program
- Government Emergency Telecommunications Service (GETS)
- Hospital Emergency Administration Radio (HEAR)
- Amateur ham radio clubs
- Other local community resources

PATIENT RECEPTION PLANS

Purpose

The purpose of this annex is to provide additional guidance to assist the Federal Coordinating Center (FCC) National Disaster Medical System (NDMS) Area Coordinator in his or her duties and responsibilities for developing patient reception plans and maintaining the support of hospitals and area agencies for the assigned FCC area of responsibility. This annex is a supplement to the NDMS FCC Guide dated April 1999.

Responsibilities

Reception and local transportation of patients destined for an NDMS facility is the ultimate responsibility of the FCC. The FCC Area Coordinator must ensure that a Patient Reception Team (PRT) is developed and remains viable through training and administrative follow-up (periodic exercises and tracking of named individuals on this team). Wherever the site is located, the FCC Area Coordinator must initiate and maintain a relationship with whomever manages this site and make such arrangements part of the FCC operations plan. In some locations, the DoD facility (FCC) responsible for maintaining the arrival site (of patients) must formulate plans including reception, staging and transportation of patients to the VAMC or NDMS member hospitals. In either case, there must be close coordination between VA and military personnel. The FCC Area Coordinator is responsible for notifying all agencies involved as soon as activation is anticipated.

Concept

1. PATIENT RECEPTION TEAM (PRT): A PRT is a multi-function group and consists mainly of clinical staff but should also include appropriate support from medical administration and communications personnel, logistics personnel, and people acting as litter bearers and drivers. The commander can be a physician or other person with an emergency medical background. This team can be based out of a federal facility (VA or DoD) or comprised of volunteers from community organizations. As well, Disaster Medical Assistance Team (DMAT) staffs make exceptional Reception Team members if they are available to the FCC. Affiliation with local Emergency Medical Service (EMS) volunteers who perform dispatch and ambulance transportation can be helpful. These personnel are very familiar with what needs to occur following a mass casualty incident in their community and can be most helpful to the FCC in either assisting or serving on the PRT. Examples of some PRTs are: VA based medical personnel, paramedics and EMTs, DMATs or a combination of all - any team that works

is fine. All PRT members, whether VAMC employees, volunteers from community organizations or a combination of both, must have regular training as a team.

2. PATIENT RECEPTION SITE: The Patient Reception Site (PRS) utilized by the FCC can be located anywhere the arrival of patients is anticipated (e.g. airport, train station, etc.). Planning is required for preparation of the Reception Site to ensure adequate security, environmental support (heat, water, light), communications, sufficient access for patient care, and egress for transportation to the NDMS facilities. Close coordination is required with DoD, civil airport authorities, EMS providers, city emergency planners and other agencies and organizations as appropriate to ensure preparation, readiness and security during arrival operations. The PRS should be part of regular training exercises. With the possibility of only 24 hours advance notice on emergency arrivals, planning is a must. The FCC operations plan should include procedures for the PRS.

3. TRANSPORTATION OF PATIENTS FROM ARRIVAL SITE: It is the Area Coordinator's responsibility to plan or work with an existing local system that provides for transportation of patients after their reception to local medical facilities. This component of the Reception Plan must encompass a system to provide the appropriate type of transport based on medical need. The Area Coordinator must do an initial assessment of the area to determine what, if any, VA or DoD transportation assistance to medical centers is available. If additional resources are necessary, this must be planned well in advance of any emergency that involves incoming victims. Additional sources of transportation are:

- Contracts with local providers who already work with the Area Coordinator
- Use of EMS already in place (best way)
- Use of Military Units if available (least likely)

A transportation plan should also address the shortest routes to be followed and include alternate routes. Advance coordination with DoD and/or local law enforcement agencies should be made in the event that traffic control and additional security are needed.

Area Coordinators should note that transportation is a major component of throughput. Therefore, plans should be very specific in how transportation assets will be employed as a disaster progresses.

4. TRACKING OF PATIENTS: This begins with the dispatch or transportation officer on the PRT. The Area Coordinator should ensure that the following information be included in the tracking system adopted by the FCC:

- Name
- Social security number
- Home address
- Next of kin with address and telephone number

- FCC name
- Admitting hospital with address and point of contact name and telephone number

The data must be retained by the Area Coordinator for a minimum of one year after the last patient has been returned home. All appropriate patient confidentiality procedures, including protection of social security numbers, must be followed.

FCC/NDMS TRAINING

Purpose

The purpose of this annex is to provide additional guidance to assist the National Disaster Medical System (NDMS) Federal Coordinating Center (FCC) Area Coordinator in his or her duties and responsibilities for providing education and training opportunities to personnel in NDMS member hospitals and within the FCC area who are involved in bed reporting, patient reception and transportation. This annex is a supplement to the NDMS FCC Guide dated April 1999.

Responsibilities

The Director of the Federal Coordinating Center is responsible for training appropriate government and civilian personnel in all aspects of the operation of the FCC.

Concept

Education and training opportunities for all FCC personnel are basic requirements for the successful functioning of an FCC. A well-thought-out program with definitive goals and objectives can serve as a recruitment tool or a means by which a member hospital can satisfy portions of JCAHO requirements.

The foundation for such training exists in several key documents:

- The FRP provides the framework for all disaster relief programs.
- The FCC Guide provides the roles and responsibilities within the FCC.
- The FCC Reception Plan provides the procedures that will be followed when NDMS has been activated and patients are being regulated and transported.

Successful training programs depend on each participant's full understanding of these key documents.

Training can be didactic or practical, periodic or continual, but should take into consideration the needs and limitations of the target audiences. Training programs developed in the various FCCs will be different from each other for the simple reason that very few FCCs will have the same structure and practices.

This Annex will not attempt to set a template for training, but will provide a series of helpful hints that can be used to develop a new program or improve an existing one.

Considerations

The first characteristic of a successful program is that each person understands the purpose of the organization, their role within it, and how it fits into the “big picture.” One way to accomplish this is to ensure that all participants receive, or have access to, the FRP, the FCC Guide, and the FCC Reception Plan.

Training programs should be planned with specific goals in mind. Complexity and scope must be clearly defined. It is not necessary to test and provide training on the entire plan at each exercise, nor do all participants need to be included at all exercises. Selected portions of the Plan can be explained or exercised by focusing on specific functions.

Didactic training, combined with practical exercises that test the FCC Reception Plan, is an approach that allows participants the opportunity to see the practical application of the formal program guidelines.

Training or exercise requirements of member hospitals or support groups that relate to FCC functions are a source of ideas from which to develop programs that can help fulfill the participants’ training requirements.

PATIENT CARE RESOURCES/BED REPORTING

Purpose

The purpose of this annex is to provide additional guidance to assist the Federal Coordinating Center (FCC) National Disaster Medical System (NDMS) Area Coordinator in his or her duties and responsibilities for collecting and reporting beds available for use by the NDMS through the Global Patient Movements Requirements Center (GPMRC), Scott Air Force Base, IL during wartime or domestic disasters. This annex is a supplement to the NDMS FCC Guide dated April 1999.

Responsibilities

The Director of the FCC is responsible for all functions ascribed to the FCC. The most basic of these functions is that of providing bed availability reports to the GPMRC. To accomplish this critical mission, the Director of the FCC must ensure that the following are accomplished:

General

1. Provide training to member hospitals on the materials in this annex. This includes providing a means by which member hospitals can report available beds to their local FCC.
2. Provide the GPMRC with a primary and alternate point of contact to ensure 24-hour availability as needed.
3. Participate in nationwide NDMS quarterly and ad-hoc bed reporting exercises.
4. During FCC NDMS activations, member hospitals may be required to provide daily bed reports.

NDMS Operations

1. Alert member hospitals when an NDMS activation is imminent that may require FCC involvement.
2. Canvass member hospitals for the ability to participate in bed reporting and patient reception. Note: It is understood that local exigencies may, at times, preclude the participation of a member hospital in a particular NDMS contingency.
3. Notify member hospitals when an NDMS activation has occurred that requires FCC involvement.

4. Receive bed-reporting instructions from GPMRC.
5. Report FCC bed availability totals to the GPMRC in accordance with issued instructions.

Definitions:

Staffed Bed - An accommodation in a functioning medical treatment facility that is currently set up and ready for the care of a patient. It must include supporting space, equipment, medical materiel, ancillary and support services, and staff to operate under normal circumstances.

Bed Report - The submission of a hospital's real-time capacity to receive, admit, and treat patients from a disaster or war.

Capability - The maximum number of patients a facility can accommodate.

Capacity - The number of patients that a facility can accommodate at a given point in time.

Category - One of 13 specific areas of medical care used to identify the nature of a patient's illness/injury as well as to identify the capability/capacity of a hospital. Currently, the categories are:

<u>CATEGORY</u>	CODE
Medical	MM
Psychiatry	MP
Surgery	SS
Neurosurgery	SSN
Maxillofacial Surgery	SSM
Ophthalmology	SSO
Thoracic Surgery	SSCT
Urology	SSU
Orthopedics	SO
Spinal Cord Injury	SCI
Burns	SBN
Obstetrics and Gynecology	SG
Pediatrics	MC

Regulate - The process of correlating patient needs with hospital capacity and capability to determine the best location to which a patient should be sent.

Throughput - The number of patients that can be processed through the local system from arrival at the casualty reception point through admission to the FCCs' member hospitals. This includes the ability of the receiving site (e.g., airport, train station) to

receive and triage patients, the local transportation system to transport patients to the hospitals, and the hospitals' capability to process and admit patients within a 24-hour period.

Procedures

Determination of bed availability:

Assessment: The starting point for the task of determining beds available is whether or not staff is present or can be obtained to provide the services represented within each category. Then, workload factors need to be considered. That is, how many patients can the clinical staff treat and manage in a 24-hour period. The decision of which option(s) to select depends on the interrelationships between currently housed inpatients, services, staff, ancillary staff, and materiel. Once the mix of specialties is established, physical space needs to be allocated, again considering the interrelationships. The final "count" will then reflect the most efficient use of hospital resources.

As the need for hospital beds continues, the methodology remains substantially the same. However, other factors need to be considered. When GPMRC regulates a patient to an FCC, the Area Coordinator must realize that the patient(s) may not arrive immediately. It may occur that two additional bed reports could be submitted before the patient actually arrives. The NDMS Area Coordinator must ensure a plan is in place to account for patients regulated but not received in order not to overstate beds available. How that plan is constructed depends upon whether the Area Coordinator assigns regulated patients to a particular hospital prior to reception. Also, if the need for hospital beds increases as the situation continues, it may become necessary for member hospitals to curtail admissions and/or increase discharges.

As the final daily report to GPMRC is prepared, consideration must be given to the throughput ability of the FCC infrastructure (See definition above). For instance, it makes no sense to regulate 250 patients to an FCC if only 100 patients can be received, triaged, transported and admitted to member hospitals in a timely manner. That is not to say that only 100 beds should be reported. Both figures are important to GPMRC's ability to plan effectively.

Reporting Instructions:

Bed reporting instructions are issued by GPMRC upon receiving authority from DoD, Health Affairs and/or TRANSCOM. Bed reports are not to be sent to GPMRC until the reporting instructions have been issued. The instructions will typically include the time period during which reports are to be sent, the format to be followed, the mode of reporting, and points of contact.

Frequently Asked Questions

What does it mean when the report indicates that a bed is available?

When an FCC report shows 10 beds available, the expectation is that until another report says otherwise, GPMRC can regulate and send 10 patients to that FCC as soon as possible.

Does the bed need to be vacant at all times until a war or disaster victim arrives?

No. The FCC makes a commitment to provide the bed when the patient arrives.

What if there are limitations to provide care under a bed-reporting category?

That should not preclude reporting some capability or capacity, nor should it result in a hospital receiving patients it cannot treat. To account for these possibilities, the current bed-reporting format now contains a comments section in which the hospital can indicate a lack of, or limitation to, capability in a specific category.

RECRUITMENT AND MAINTENANCE OF HOSPITAL SUPPORT

Purpose

The purpose of this annex is to provide additional guidance to assist the National Disaster Medical System (NDMS) Federal Coordinating Center (FCC) Area Coordinator in his or her duties and responsibilities for recruiting and maintaining the support of hospitals and area agencies for the assigned FCC area of responsibility. This annex is a supplement to the NDMS FCC Guide dated April 1999.

Responsibilities

The Area Coordinator is assigned to an FCC that is responsible for establishing and maintaining the support of area hospitals, government agencies, volunteer organizations, and others for the assigned FCC area of responsibility.

The Area Coordinator is the field representative for the FCC and is responsible for establishing and maintaining the active participation and support of area hospitals, EMS organizations, local government agencies and numerous other organizations.

The Area Coordinator is responsible for the day-to-day operation and readiness of the local NDMS program. He/she is the essential link in obtaining and maintaining community support and participation in the NDMS.

Procedures

Solicit and Organize Community Support and Participation

1. The success of a local NDMS program requires the active participation and support of numerous organizations that pledge their support for the NDMS. Local agencies and organizations that should be considered for participation in the local NDMS program include:

- Area hospitals
- Local hospital associations
- Local medical associations
- Local, county and state emergency management agencies
- Local emergency medical services agencies
- Local RACES (Radio Amateur Communications for Emergency Services) and ARES (Amateur Radio Emergency Services) organizations
- Local American Red Cross Chapter(s)
- Local Salvation Army
- Local airport authority
- Area transportation agencies

- Local military organizations
- Local volunteer organizations
- Local medical/education training institutions
- Local businesses
- Others, as appropriate

2. LAY THE GROUNDWORK

- a. Research history
 - (1) Old MOUs
 - (2) POC lists
 - (3) Bed reports
 - (4) Exercise reports/After action reports
- b. Determine target zone
 - (1) Basic area
 - (2) Secondary or Patient Reception Site
- c. Determine mode of contact
- d. Prepare Information package
 - (1) Introductory letter from Director, NDMS Staff Directorate
 - (2) Current MOU
 - (3) FCC Guide

3. PRELIMINARY CONTACT

- a. Establish/confirm POC
 - (1) "Old" member - Staff person
 - (2) "Potential" Member - Hospital Administrator
- b. Send out package (or part of)
- c. Set up formal contact time and location
- d. Determine if ceremony is appropriate
- e. Schedule photographer as appropriate

4. FORMAL CONTACT / SIGNING CEREMONY

5. FOLLOW UP CONTACT

Send/bring thank you/welcome letter to member hospital

6. REGISTRATION

Record membership with USPHS/OEP and EMSHG

Program Development

1. Although the NDMS is a federally coordinated program, success requires that the program be built on how the community normally responds to a local medical emergency. It is important to actively involve area hospitals, local health associations, emergency management agencies, hospital councils, medical societies, local EMS agencies, and others. It is essential that the Area Coordinator provide ongoing education and information to FCC staff and all NDMS participants.

2. The Area Coordinator must be knowledgeable of the FCC area's health care system, government structure, volunteer organizations, and geographic and other characteristics. He/she must adapt general briefings and requirements of the NDMS to meet the needs of the local community while ensuring that resources are available to support the NDMS when required.

3. The following are some of the issues that the Area Coordinator must consider when seeking the participation of hospitals and organizations in the NDMS:

- The NDMS is a voluntary organization.
- Describe to a potential participant the reason why their support and participation are critical to the success of the program.
- Mutual national support.
- Good will for the community.

4. Recruitment of hospitals is normally limited to a 50-mile radius from the FCC reception site.

a. Hospitals volunteering to participate in the NDMS should normally be within a 50-mile radius of the airport designated as the reception site for NDMS patients. This is to help assure that local ground transport of patients to a participating hospital will require one hour or less. (NOTE: Hospitals beyond a 50-mile radius may be accepted for enrollment at the discretion of the NDMS FCC.)

b. USAF will usually not transport to a second site within 100 miles of the primary FCC airport reception site.

c. The FCC may request authority from the Director, NDMS to establish a second "Patient Reception Site" (PRS) in a community that is over 100 miles away if that community can provide additional beds.

d. The Area Coordinator will be responsible for the establishment of a satellite NDMS reception site to include the NDMS reception plan and signed memorandums of understanding. (NOTE: A second PRS may be assigned a separate facility code number.)

5. A hospital wishing to participate in NDMS must agree to certain requirements and complete a Memorandum of Understanding (MOU). The Chief Executive Officer of the NDMS member hospital and the assigned Area Coordinator, who will sign the agreement as the local representative of the NDMS, will sign the MOU.

Bed Commitment Responsibilities

The Area Coordinator must make it clear to the prospective member hospitals that as part of initial enrollment in the NDMS, non-Federal hospitals will indicate in the NDMS

MOU a general total "Minimum" and "Maximum" number of beds to be committed. The "Minimum" represents the number of beds the facility estimates that it could make available within 24 hours of notification of an NDMS activation; the "Maximum" represents the greatest number of beds that could be made available (referred to by GPMRC as beds that would be used for deliberate planning). Area Coordinators should ensure that member hospitals are familiar with the reporting requirements outlined in Annex E - Patient Care Resources/Bed Reporting.

Public Relations

1. Area Coordinators are encouraged, with the advance consultation and concurrence of the participating hospital or organization, to obtain news media coverage of the agreement signing ceremony.
2. A plaque signifying NDMS participation is to be presented to hospital representatives at the signing. Requests for plaques will be submitted to the NDMS headquarters office.

Plan Development

1. **Local plan:** The development of a local plan is critical if NDMS is to be a viable system. The key to success is the thoroughness and effectiveness of local level planning. Each local community in which the NDMS is organized is unique. The degree of sophistication of current community disaster planning and the availability of local resources that can be incorporated into the NDMS plan will vary among communities. Each NDMS plan must be tailored to its community; thus local planning cannot be accomplished without the support, involvement, and coordination of the local area's medical community. Most communities have an Airport Disaster Plan, Mass Casualty Incident (MCI) Plan. In many instances, this can be used as a basis for the NDMS Reception Plan or at least the same people and organizations that developed these plans should help develop and manage the NDMS plan. Local officials who help develop the plan will be familiar with, and will more likely accept use of, their own plan for NDMS disaster response.

2. **Plan development process:** In the plan development process, there are a number of individuals and/or agencies that the Area Coordinators should contact. These include local emergency medical service organizations, county and city health departments and disaster planning agencies, disaster-planning committees of medical societies and hospital associations, and selected individuals who are leaders in the local health care community.

3. Transportation:

a. Area Coordinators are responsible for arranging transportation to move patients from arrival sites to local NDMS member hospitals. It is possible that 50 to 100 patients could arrive simultaneously in a local NDMS area with little advance notice.

Area Coordinators must have incorporated into the NDMS Area Operations Plan procedures to obtain vehicles and personnel medically appropriate for the patients' conditions.

b. It is important that non-EMS vehicles be assessed for their patient carrying capability and capacity, inventoried, and tabulated in the patient transportation plan. Additionally, advance coordination should occur with the authorities that will make these vehicles available.

c. Area Coordinators may arrange to obtain the services of commercial and school buses to transport ambulatory patients if the need arises. Although most buses cannot accommodate litter patients; their capability to be used for this purpose should be assessed (e.g., special needs vehicles that are wheelchair accessible or otherwise configured to accommodate litter patients).

Hospitalization

1. Maximum effectiveness in the overall hospitalization process can be obtained only through close coordination and cooperation between the Area Coordinator and the participating hospitals in the NDMS Patient Reception Area. This effectiveness is achieved by linking the Area Coordinator with the NDMS member hospitals through the patient administration activity of each medical facility.
2. The Area Coordinator assumes administrative responsibility for hospitalized patients. This responsibility begins upon a patient's arrival and continues until the patient is either returned home or, in the case of military casualties, returned to the responsible service personnel system for processing and assignment to a military unit or discharge from active duty, as appropriate.
3. On admission to a participating NDMS hospital, the patient's day-to-day medical management and care will be accomplished by the medical staff of that hospital. The hospital will provide for the complete acute care of the patients using their own procedures and forms.
4. NDMS member hospitals will be required to provide information to the Area Coordinator to include a daily admission and disposition list (indicating the expected length of stay) and a narrative summary upon discharge of the patient.
5. In some cases, during and after a military contingency, military patient administration teams may be provided to assist the Area Coordinator to coordinate military patient and personnel matters between NDMS member hospitals, the Area Coordinator, and the local military hospital. The decision to establish the team, as well as its makeup, will depend on the projected workload, communications capability, distance between participating hospitals, patient needs, and the requirements of the participating hospital as well as the Area Coordinator. Area Coordinators should coordinate with the nearest

military hospital to establish procedures to be followed for all military personnel, regardless of service.

Claims Submission, Processing, and Payment

Care will be compensated at 110% of what Medicare would pay on a last dollar basis (at the time of the disaster). Claims submission, processing and payment procedures are currently under development.